APPLICATION FOR SELF-INSURANCE

State of Kansas
Department of Human Resources
Division of Workers Compensation

_____ Date of Application

_____ Permit Number

_____
Applicant Organization Name

hereby applies for the privilege of being a self-insurer under the Kansas Workers Compensation Act and submits the following report in support of said application.

All Questions Must Be Answered - If Not Applicable - put N/A

1. Address of principal office_____

2. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Public Authority

3. Applicant's general officers, partners or public officials:

Name/Title	Business Address
_____	_____
_____	_____
_____	_____
_____	_____

4. Date applicant's business/public authority commenced _____

5. Person responsible for self-insurance program:

_____ Name _____ Title _____ Telephone Number

_____
Address of Responsible Person (if different from item 1 above)

6. Service company information

   a. Loss prevention services:

      (1) Name of service company_____

      (2) Address of service company_____

      (3) Telephone number_____

      (4) Contact person_____

      (5) Give details of services furnished by service company _____

      _____

      _____

      _____

      _____

b. Claims handling services:

(1) Name of service company_____

(2) Address of service company_____

(3) Telephone number_____

(4) Contact person_____

(5) Give details of kinds of services that will be furnished by service company _____

_____

_____

_____

_____

If you DO NOT plan to use an adjusting company, please explain on a separate attachment the plan you have for adjusting claims for your company. Such explanation should include the name of the person directly in charge of the adjusting activity. Explain what procedure you plan to follow in regard to investigating and adjusting claims and whether those individuals adjusting claims will be exclusively engaged in that activity.

The Division of Workers Compensation may require the use of an adjusting company if we do not feel that your in-house adjusting procedure would be adequate to serve the injured workers.

DO THE ABOVE 5. AND 6. (a) AND (b) HAVE A WORKING KNOWLEDGE OF THE KANSAS WORKERS COMPENSATION ACT? ☐ Yes ☐ No

7. Safety program

a. Person in charge_____

b. Please furnish a copy of the engineering report which gives a description of the risk's operations from raw material received to finished product and engineer's evaluation of the safety program.

If unavailable, a copy of your safety manual will be acceptable. If previously filed, only changes need to be submitted.

c. When were premises last inspected? _____

Inspecting agency_____

8. Medical and hospital care

a. Do you employ a full or part-time doctor? ☐ Yes ☐ No

Name_____

b. Name of physician to whom injured are normally sent _____

c. Do you have a hospital in the plant? ☐ Yes ☐ No

First aid room? ☐ Yes ☐ No

Professional nurse on premises? ☐ Yes ☐ No

9. Loss History (5 years) for state of Kansas (new permit applications only)

Liability Period		Gross Payroll	Total Losses	Paid Losses	Reserves	National Council on Compensation Experience Modification
From	To					

10. Give the following information regarding the state of Kansas: (If more space is needed, use separate page.)

*W.C. Code No.	* Classification	Number of Employees	Estimated Annual Gross Payroll	*Current Manual Rates	Manual Premium

* Generally available from your insurance agent or excess carrier. Use the current approved Assigned Risk Rates. These rates are measurable for manual premium determination.

Total number of employees in Kansas_____

Total Estimated Manual Premium_____

11. For the state of Kansas indicate the workers' estimated average weekly wage:

$_____ (exclude clerical and executive wages)

12. Applicant will submit or has in effect:

a. Specific Excess Insurance

Policy limit $_____

Retention $_____

Term _____ years

b. Aggregate Excess Insurance

Policy Limit $_____

Loss Fund Percentage _____

Minimum Loss Fund $_____

Estimated Loss Fund $_____

Policy Term _____

c. Date Self-insured authority to become effective*

_____

d. Excess Insurance Renewal Date

_____

* N/A for renewal

13. Do you have any owned, leased * or chartered aircraft? ☐ Yes ☐ No

Does your excess policy cover this additional exposure? ☐ Yes ☐ No

*Leased aircraft: one that is not owned by the applicant and made available for the use of the applicant under the terms of a rental or lease agreement for a period of not less than thirty (30) consecutive days, and operated by someone other than an employee of the owner or lessor of such aircraft.

14. List the states or jurisdictions in which this applicant operates as a qualified self insured. (Use separate sheet if necessary)

_____

_____

_____

_____

_____

_____

a. If you have ever been denied a self-insured permit or non-renewal in any state, please indicate the name of the state and why you were not accepted or not renewed. (Use separate sheet if necessary)

_____

_____

_____

_____

_____

_____

_____

15. Give the following totals for the most recent year and prior years experience information for each state where qualified as a self-insurer. (Use additional sheet if necessary) If unavailable on a state-by-state basis, combined totals may be given.

State	Most Recent Calendar Year Dates		Total Average Number of Employees	Total Annual Gross Payroll	*Indemnity Paid	*Medical Paid	**Total Indemnity Unpaid (Reserves) See Below	**Total Medical Unpaid (Reserves) See Below
	From	To						

* Include current and ALL prior years
** Include current and ALL prior years for payment in future by self-insured and not by insurance carrier.

16. Please give the following information about each Kansas death, disability or disease claim in the past five (5) years with costs in excess of $30,000. (Use a separate page for full details)

Date of Loss	Number of Employees Involved	Facts of Loss, Type of Injury or Disease and State Benefits Applicable	Total Estimated Cost		
			Indemnity Paid	Medical Expense Paid	Total Unpaid

17. Do employees receive any supplemental benefits in addition to workers compensation benefits? ☐ Yes ☐ No

If yes, describe _____

_____

_____

18. Are there any actual or potential occupational disease exposures involved in applicant's operations? ☐ Yes ☐ No

If yes, describe _____

_____

_____

19. Please furnish information on any substantial or unusual changes (increase or decrease) in operations in Kansas that are planned or that have taken place in the last five (5) years. (If necessary, use additional sheet and identify as Attachment(s).)

_____

_____

_____

20. Does the applicant have any employees in Kansas who are subject to the:

Longshoremen and Harbor Workers' Act? ☐ Yes ☐ No

Jones Act? ☐ Yes ☐ No

Federal Employers' Liability Act? ☐ Yes ☐ No

If yes, explain_____

21. a. If the employer is rated by Standard & Poor or Dun & Bradstreet, show the latest ratings, INCLUDING the date of the rating: (Ultimate Parent rating if application is submitted by subsidiary).

Standard & Poor _____ Dated: _____

Dun & Bradstreet _____ Dated: _____

Other _____ Dated: _____

b. Give four-digit Standard Industrial Classification (SIC) Code that most clearly defines your operation as reflected in the financial statements submitted. (Ultimate Parent SIC if application is submitted by subsidiary) _____

The SIC Code is used to determine the appropriate Dun & Bradstreet reference for comparing financial condition to the industry norm. If verifiable information from an industry association would be more appropriate, please submit.

The Standard Industrial Classification (SIC) Code defines industries in accordance with the composition and structure of the economy. Each establishment is classified according to its primary activity; i.e., mining, construction, manufacturing, transportation, communications, utilities, wholesale trade, retail trade, services, etc. In Kansas, the SIC Code is assigned by Kansas Department of Human Resources (KDHR) Labor Market Information Services, under contract with the Federal Bureau of Labor Statistics. Each business with one or more employees must file an "Employer's Quarterly Wage Report and Contributions Return", Form K-CNS 100, with KDHR. The SIC Code is shown on the "Employer's Quarterly Wage Report and Contributions Return," lower right portion following Item 17, received each quarter from KDHR (generally available from your accountant).

22. PARENT(S), AFFILIATES AND SUBSIDIARIES OF APPLICANT:

..... List parents of Applicant in hierarchical order, beginning with ULTIMATE PARENT COMPANY regardless of Kansas operation.

..... List all affiliates and subsidiaries of Applicant that are operating WITHIN KANSAS.

..... Place an arrow (Ž) in column one (1) showing Applicant's direct parent company.

List % of voting stock by each corporation's direct parent, and show whether corporation is a parent or subsidiary of the applicant.

Column 1	Legal Name of Corporation	Address of all Kansas Locations	(%)	Parent or Sub.
TOP PARENT				

23. APPLICANT DIVISIONS AND OPERATION: Year _____

List each Kansas operation of the Applicant (Do not list excess insurance on this chart.)

Name of Operating Unit and Location (Include Street Address)	Operation Type Main Products, Services, Activities	Kansas Employees		No. Cases Entered on OSHA 200 log	** To be Self-Ins.	
		Average Number	Annual Gross Payroll		Yes	No
			$			
			$			
			$			
			$			
TOTALS			$			

**If no, list: (1) Full name of insurance Company_____,

(2) policy number_____ and (3) policy ending date_____.

If no, does this unit have separate employees and payrolls? ☐ Yes ☐ No

24. EXCESS INSURANCE:

List all excess policies that cover Kansas Workers Compensation Insurance (Check which type of excess in force)

Coverage Type: ☐ Specific ☐ Aggregate ☐ Other

Insurance Company (Full Name)	Retention	Upper Limit of Excess Policy	Policy No.	Policy Period	
				From	To
	$	$			
	$	$			
	$	$			
	$	$			

25. ALL APPLICATIONS

A. PAID LOSS DATA FOR OUTSTANDING WORKERS COMPENSATION CLAIMS

(Includes weekly compensation payments, travel and per diem for medical exams and or treatment, lump-sum payments, compromise settlements, hospital, appliance and medical payments, rehabilitation, and death and funeral benefits.)

Amount Paid For Medical: **$** _____

(including payments made during the calendar year for any previous years accidents.)

Amount Paid For Indemnity **$** _____

(including payments made during the calendar year for any previous years accidents.)

Total Amount Paid in Recent Calendar Year: # **$** _____

 # This figure must equal amount shown on K-WC 92, Annual Loss Payment Reporting Form, which is: $_____ (Reflect Form 92 figure.)

B. RESERVES FOR CLAIMS TO BE PAID IN THE FUTURE

(1) RESERVE INFORMATION FOR ALL KANSAS CLAIMS INCLUDING PRIOR YEARS, CURRENT YEAR, AND OCCURRING FROM JANUARY 1 THROUGH _____

Total Number of Claims: _____

Amount Reserved For Known Medical: **1a** **$** _____

Amount Reserved For Known Indemnity **1b** **$** _____

(2) INCURRED BUT NOT REPORTED (IBNR) CLAIMS

Total Number of Claims: _____

Amount Reserved For IBNR: **2a** **$** _____

(3) RESERVED FOR FUTURE CLAIMS: **3a** **$** _____

TOTAL AMOUNT RESERVED: **$** _____

(1a+1b+2a+3a)

C. ACCIDENT INFORMATION

During the most recent calendar year of _____ (year) there was _____ (number) accidents reported.

The accidents reported were _____ (number) time lost _____ (number) no time lost.

D. NAME, QUALIFICATIONS AND EXPERIENCE OF PERSON(S) EVALUATING LOSS RESERVES

(Resume or attachment will be acceptable.)

_____

_____

E. HOW ARE LOSS RESERVES FOR FUTURE LIABILITY EXPRESSED ON YOUR FINANCIAL STATEMENT

_____

26. Provide name of responsible individual as contact for the following areas:

a. Notice of Hearing:

Name: _____

Address: _____

_____

Telephone number: _____

b. Renewal Application:

Name: _____

Address: _____

_____

Telephone number: _____

c. Notice of Assessment:

Name: _____

Address: _____

_____

Telephone number: _____

d. Applicant's FEIN Number: _____

SETTLEMENT AND STIPULATIONS

Employer must agree to the conditions and stipulations below to qualify for self-insurer privileges. This statement must be signed by a corporate officer; city or county official; partner; or individual; and have applicant's seal affixed before self-insurer privileges will be considered.

27. In consideration of the privilege of being a self-insurer in the state of Kansas, I hereby agree:

a. That I have filed all required reports and paid all fees necessary to remain a Corporation in Good Standing with the Office of the Secretary of State of Kansas (785-296-4564).

b. That I will discharge my liability for compensation to injured employees or their dependents in accordance with the requirements of the Workers Compensation Act of the state of Kansas.

c. That I will not solicit, receive or collect any money from my employees or make any reduction from their wages and commissions for the purpose of discharging any part of my liability under the Act.

d. That I will promptly furnish all reports to the Kansas Division of Workers Compensation which it may lawfully require under the Kansas Workers Compensation Act.

e. To notify the Division of Workers Compensation in any case of contemplated liquidation, sale or transfer of ownership, or material reduction in Kansas operation. Subject to the Division of Workers Compensation approval, I will arrange for the payment of all existing liability and any liability arising thereafter for which I may become legally liable, by guaranty bond, deposit of securities, or as otherwise required by the Division of Workers Compensation.

f. That prior to any changes made to the excess insurance policy, I will request from the Division of Workers Compensation approval of the self-insured retention or policy limits, and I agree that any proposed changes will be justified in narrative form prior to the inception of the policy or date of renewal.

g. That I will notify the Division of Workers Compensation at least twenty (20) days in advance of any change in excess insurance carrier. I am familiar with the insurance laws in Kansas regarding the placement of excess insurance in the admitted and non-admitted excess insurance market. Also, I am aware of the hazards of having excess workers compensation coverage with a non-admitted insurance carrier.

h. To let the Division of Workers Compensation know about any change in the kind or amount of services to be performed by the service company, if a company is used.

i. That I will promptly notify the Division of Workers Compensation of any unfavorable turn in my financial condition which might reasonably reduce my ability to carry my own risk under the Kansas Workers Compensation Act.

j. That the Form K-WC 40, Posting Notice, will be displayed in conspicuous places, such as employee bulletin boards as required by the Kansas Workers Compensation law. (The notices are available at no charge from the Division of Workers Compensation.)

k. Immediately on receiving notice of injury to or death of an employee, the employer shall mail or deliver to the employee or legal beneficiary a clear and concise description of:

(1) the benefits available under the workers compensation act;

(2) the process to be followed in making a claim for benefits;

(3) the identification of the person, firm or organization directly responsible for responding to and processing a claim for workers compensation benefits;

(4) the responsibilities of the self-insured employer, insurance company or group-funded self-insurance plan;

(5) the assistance available from the office of the director of workers compensation; and

(6) the address and a toll-free telephone number that will facilitate access to the assistance available from the director's office.

j. That in case of insolvency I shall make our records available to the Division of Workers Compensation. I will also disclose our inability to pay the injured employee. I hereby agree to all other requirements contained in K.S. A. 44-532, 74-712 through 74-719 and K.A.R. 51-14-4.

k. That I recognize that this self-insurer permit can be cancelled at anytime for failure to comply with the requirements set out herein.

EMPLOYER _____

APPLICANT'S
OFFICIAL
SEAL

SIGNED BY _____
(Corporate Officer, Official of City or County Government, Partner or Individual)

Official Position _____
(The person signing the application above and subscribing the affidavit below must be the corporation President, Vice President, Secretary or Treasurer, or the corporation Assistant Secretary or Assistant Treasurer if authorized by articles of incorporation or bylaws to make this application.) (Authorized official if city or county government.)

STATE OF_____)
)
_____ COUNTY)

AFFIDAVIT

_____, First being duly sworn on oath, deposes and says that he/she is the person who signed the foregoing application, and that he/she is acquainted with the affairs of the said applicant employer, to which the representations and statements set forth in the foregoing application relate; that he/she has read said application, knows the contents thereof and that said representations and statements therein contained are true to the best of his/her knowledge, information and belief.

_____ _____
(Affiant's Signature) (Official Position)

Subscribed and Sworn to before me at _____, _____,

this _____ day of_____, 20_____.

_____
(Notary Public)

(SEAL)

MY COMMISSION EXPIRES _____